CareFirst Specialty Pharmacy
2200 Garry Road Suite 1 Cinnaminson, NJ 08077 Office:
856-267-0528 / Toll Free: 844-822-7379 Fax:
856-267-0529 / Toll Free: 844-922-7379
E-mail: info@cfspharmacy.com
www.cfspharmacy.com

Credit Card Authorization Form

Name: _____ **Date:** _____

Company Name: **(if applicable)** _____

Phone #: _____

Email: _____ **Fax #:** _____

This approval form must be **signed by the cardholder** (who is the Cardholder/Owner/Officer/Partner in the company) authorizing CareFirst Specialty Pharmacy to debit the specified credit card.

Cardholder Name:
(Name as shown on card; PLEASE PRINT) _____

Card Type

American Express ☐ MasterCard ☐ Visa ☐ Discover Card ☐

Credit Card #: ☐☐☐☐ - ☐☐☐☐ - ☐☐☐☐ - ☐☐☐☐

Card BILLING Address:
(**FULL** billing address where credit card statement is sent)

_____
Street Address

_____
City State/Province Zip/Postal Code

Expiry Date: _____

Verification Code: _____
(the last three digits of the number located in the signature line on the back of the credit card for Visa, MC, Discover. 4 digits on front of American Express)

CareFirst Specialty Pharmacy is hereby authorized to accept orders from individual/business indicated above, charge the cost this/these order(s) to the above credit card account and ship the merchandise as requested. By signing this document, I/we accept full responsibility for these transactions and ensure full payment to CareFirst Specialty Pharmacy. I will inform CareFirst Specialty Pharmacy immediately if use of the card is no longer authorized.

I hereby authorize CareFirst Specialty Pharmacy to use this credit card account until further notice:

Signature: _____